Case No. 80-419

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1980

Office-Supreme Court, U.S.
FILED
JUN 11 1981
ALEXANDER L. STEVAS,
CLERK

STATE OF ARIZONA

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
Maricopa Foundation for Medical Care, and
Pima Foundation for Medical Care.

Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS, FOR THE NINTH CIRCUIT

BRIEF FOR THE STATE OF OHIO *AMICUS CURIAE* SUPPORTING THE STATE OF ARIZONA

WILLIAM J. BROWN
Attorney General of Ohio

CHARLES D. WELLER
Assistant Attorney General
Counsel of Record for State of Ohio

DOREEN C. JOHNSON
Assistant Attorney General

810 State Office Building
615 West Superior Avenue
Cleveland, Ohio 44113
(216) 622-3030

Counsel for State of Ohio
Amicus Curiae

of Counsel:

EUGENE F. McSHANE
Assistant Attorney General
Chief, Antitrust Section

INDEX

Page

Interest of Amicus Curiae 1
Summary of Argument 3
Argument 3

I. RELEVANT BACKGROUND ON THE HEALTH CARE INDUSTRY, THE GUILD MODEL AND THE COMPETITIVE ALTERNATIVES 3

A. The Persistant Problem of Soaring Health Care Costs 3

B. The Underlying Cause: The Perverse Incentives, or the Absence of Price Competition Among Providers 4

C. The Competitive Alternative: Provider Price Competition Over Fees and Premiums 7

D. Medical Guild Opposition to Price Competition Among Providers 10

II. THE MEDICAL SOCIETY FOUNDATIONS ARE ILLEGAL DOCTOR GUILDS OR UNIONS COLLECTIVELY BARGAINING FEE AGREEMENTS FOR 70% OF AREA PHYSICIANS WITHOUT AN ANTITRUST EXEMPTION 14

Conclusion 25

INDEX TO AUTHORITIES

Cases: **Page**

American Medical Assn. v. United States,
317 U.S. 519 (1943) 11, 14
Anderson v. Medical Service of the District of Columbia,
1976-1 CCH Trade Cases Para 60,884 (E.D.
Va. 1976), *aff'd* 551 F.2d 304 (4th Cir. 1977).....12, 20
Catalano, Inc. v. Target Sales, Inc.,
446 U.S. 643 (1980) 17
Doctors', Inc. v. Blue Cross of Greater Philadelphia,
557 F.2d 1001 (3rd Cir. 1976) 12
Goldfarb v. Virginia State Bar,
421 U.S. 773 (1975) 22
Grigg v. Blue Cross & Blue Shield of Michigan, Inc.,
No. 772990 (E.D. Mich., filed Dec. 22, 1977).....12
Group Life & Health Insurance Co. v. Royal Drug Co.,
440 U.S. 205 (1979).....12, 18, 19
In re American Medical Assn.,
94 F.T.C. 701 (1978), *aff'd* 1980-2 CCH Trade Cases
Para 63,569 (D.C. Cir. 1980)... 7, 10-13, 15, 16, 18, 19, 21
Kartell v. Blue Shield of Massachusetts, Inc.,
592 F.2d 1191 (1st Cir. 1979) 12, 20
Manasen v. California Dental Service,
1981-1 CCH Trade Cases Para 63,959
(N.D. Calif. 1980) 12
National Gerimedical Hospital v. Blue Cross of Kansas City,
No. 80-802 (S. Ct., case argued April 29, 1981).....6
National Society of Professional Engineers v. United States,
435 U.S. 679 (1978) 14, 22
Nationwide Trailer System, Inc. v. United States,
156 F. Supp. 800 (D. Kan.), *aff'd* 355 U.S.
10 (1957) 17
Northern Pacific R. Co. v. United States,
356 U.S. 1 (1958).....14
Ohio v. Alliance Dental Society,
1976-1 CCH Trade Cases Para 60,944 (Ohio C.P.) 2
Ohio v. Greater Cleveland Hospital Assn.,
No. C-80-1305 (N.D. Ohio, complaint filed July, 1980) ...2
Ohio v. Joint Commission for the Accreditation of Hospitals,
No. C-2-79-1158 (S.D. Ohio, complaint filed
Dec. 14, 1979).....2
Ohio v. Mahoning County Medical Society,
1978-2 CCH Trade Cases Para 62,226 (N.D. Ohio 1976)....2

Page

Ohio v. Ohio Dental Assn.,
No. C-2-79-1058 (S.D. Ohio, settlement order
Nov. 15, 1979).....2
Ohio v. Ohio Optometric Assn.,
No. C-2-80-388 (S.D. Ohio, complaint filed
May 12, 1980).....2
Ohio v. Ohio State Medical Assn.,
5 CCH Trade Regulation Rep. Para 50,396 (S.D. Ohio,
May 7, 1979).....2
Plymouth Dealers Assn. v. United States,
279 F.2d 128 (9th Cir. 1960).....17
Sausalito Pharmacy, Inc. v. Blue Shield of California,
1981-1 CCH Trade Cases Para 63,885
(N.D. Calif. 1981).....12
Sugar Institute, Inc. v. United States,
297 U.S. 553 (1936).....16
United States v. Frankfort Distilleries, Inc.,
324 U.S. 293 (1945).....16
United States v. Line Material Co.,
333 U.S. 287 (1948).....16
United States v. Socony-Vacuum Oil Co.,
310 U.S. 150 (1940).....8, 17
United States v. Women's Sportswear Mfgrs.' Assn.,
336 U.S. 460 (1949).....16

Statutes:

15 U.S.C. Section 1.....14

Legislative Materials:

Sen. Rep. on PL 93-141, No. 93-1285, 93 Cong.,
2d Sess., *1974 U.S. Code & Admin. News* 7842.....4
Hearings on Third Party Prepaid Prescription Programs Before the Subcommittee on Environmental Problems Affecting Small Business of the H. Select Comm. on Small Business, 92 Cong., 1st Sess., 227 (1971).....20
Tax Expenditures for Health Care, *Hearings Before the Task Force on Tax Expenditures & Tax Policy of the H. Comm. on the Budget*, 96th Cong., 1st Sess.,
235 (1979).....20, 21

Other Materials: **Page**

AMA, AN INTRODUCTION TO MEDICAL ECONOMICS (1933) 13
AMA, ECONOMICS AND THE ETHICS OF MEDICINE (1936) 13
AMA, NEW FORMS OF MEDICAL PRACTICE (1933) 19
Note, *American Medical Association: Power, Purpose & Politics,* 63 YALE L.J. 937 (1954) 11
American Medical News, June 22, 1979 5
O. ANDERSON, BLUE CROSS SINCE 1929 (1975) 19
P. AREEDA & D. TURNER, 1 ANTITRUST LAW (1978) . . . 6
Breo, *Antitrust and the Medical Society,* 76 OHIO ST. MED. J. 136 (March, 1980) 22
Christianson & McClure, *Competition in the Delivery of Medical Care,* 301 NEW ENGLAND J. MEDICINE 812 (Oct. 11, 1979) 7
Clark, *Hospitalization Rates to Leap for City Workers,* Cleveland Plain Dealer 13-A, May 8, 1981 4
Competition in Health Care: Would it Bring Costs Down? CONG. Q. 1587 (Aug. 4, 1979) 7
Egdahl, *Fee For Service Health Maintenance Organizations,* 241 J.A.M.A. 588 (Feb. 9, 1979) 5
Ellwood, *The Importance of the Market,* 2 J. HEALTH, POLITICS, POLICY & LAW 447 (1978) 8, 18
Ellwood & McClure, *Health Delivery Reform* (unpublished InterStudy paper, Nov. 17, 1976) 9
Enright, *Doctors v. Blue Shield: The First Big Battle,* MEDICAL ECONOMICS 23 (Nov. 27, 1978) 12
A. Enthoven, *Consumer-centered v. Job-centered Health Insurance,* 57 HARVARD BUS. REV. 141 (Jan. 1979) . . . 21
A. Enthoven, *Cutting Cost Without Cutting the Quality of Care,* 298 NEW ENGLAND J. MEDICINE 1229 (June 1, 1978) 6, 7
A. Enthoven, *Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here,* NAT'L. J. 885 (May 26, 1979) 7
A. ENTHOVEN, HEALTH PLAN (1980) 7
Feldstein, *A New Approach to National Health Insurance,* 23 PUBLIC INTEREST 93 (1971) 8
Freeland, Calat & Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990,* 2:3 HEALTH CARE FINANCING REV. 1 (1980) 4

Page

F.T.C. Bureau of Competition *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans* (April 1979) 18-20
V. FUCHS, WHO SHALL LIVE? (1974) 6
Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?*, 58 MILBANK MEMORIAL FUND Q 89 (1980) 13
Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMPORARY PROBLEMS 716 (1970) 7
Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303 21
HEW, *Forward Plan for Health: Fiscal Years 1980-82* (1976) 4
3 HMO FOCUS 1 (Dept. Health & Human Services, Dec. 1980) 20
4 HMO FOCUS 1 (Dept. Health & Human Services, Feb. 1981) 20
G. LAMB & C. SHIELDS, TRADE ASSOCIATION LAW & PRACTICE (1971) 20
W. McClure, *Comprehensive Market and Regulatory Strategies for Medical Care* (InterStudy 1980) 7
W. McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH, POLITICS, POLICY & LAW 22 (1976) 4, 7, 8
Ohio Governments' Spending Climbs 173% in Past Decade, Cleveland Plain Dealer 10-B, Nov. 20, 1980 4
Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin*, 82 HARVARD L. REV. 1007 (1969) 23
R. POSNER, ANTITRUST (1981) 17
Rogers, *Pro-competition Bills and Socialized Medicine*, American Medical News 8, May 8, 1981 11
Schorr, *Reagan's Medicaid Plan Stirs Fears of Two-Class Health Care System*, Wall Street Journal 25, Feb. 24, 1981 11
A. SOMERS & H. SOMERS, DOCTORS, PATIENTS, & HEALTH INSURANCE (1960) 11
L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST (1977) 14, 23

Page

Waldholz, *Medical Benefit Costs are Rising Sharply; Firms Tighten Controls, Redesign Plans,* Wall Street Journal 48, Sept. 25, 1980 4
Williams, *How to Meet the New Demands in Ambulatory Care,* TRUSTEE, Dec. 1980 7
P. WILLIAMS, THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT (1932) 19

Case No. 80-419

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1980

STATE OF ARIZONA

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
Maricopa Foundation for Medical Care, and
Pima Foundation for Medical Care.

Respondents.

ON CERTIORARI TO THE UNITED STATES COURT
OF APPEALS, FOR THE NINTH CIRCUIT

BRIEF FOR THE STATE OF OHIO *AMICUS CURIAE* SUPPORTING THE STATE OF ARIZONA

INTEREST OF AMICUS CURIAE STATE OF OHIO

Private market economics and the antitrust laws are to the medical profession what Copernicus' ideas were to the western world of the 16th Century: a fundamentally new way of thinking about reality.

For decades medical societies have viewed themselves as the proper centers of health care's economic universe. Over these many years a guild mentality has become firmly embedded in medical societies and the medical profession.

Market principles, of course, are entirely different from the guild concepts that have dominated medical society thinking for so long. The center of its economic world is the market, not the medical society.

For six years the Attorney General of Ohio has had first hand exposure to the guild thinking and conduct of the health professions.[1] He is convinced that as long as that guild mentality persists, antitrust violations will proliferate. In addition, private sector efforts by the medical profession and others to control soaring health care costs will be undermined. Neither result is in the best interests of Ohio consumers or health professionals.

The instant case is of great importance to the State of Ohio because it presents a classic application of the medical guild model to private markets. An incisive opinion by this Court against the Respondents can remove these guild precepts, and replace them with private market principles. Such an opinion would greatly facilitate antitrust enforcement in the courts. It would also materially advance the most effective antitrust "enforcement" of all: a properly functioning, self-correcting, private market for health care.

---

1. *Ohio v. Ohio State Medical Assn.*, 5 CCH Trade Regulation Rep. Para 50,396 (May 7, 1979) (S.D. Ohio) (July, 1975 suit settled in March, 1979; Medical Society forced to give up its complete control of Ohio Medical Indemnity - Blue Shield - which pays physicians $300 million a year. The company is now owned by its policyholders, has a majority of new board members, and can have no more than 4 physicians on its 21 member board); *Ohio v. Mahoning County Medical Society*, 1978-2 CCH Trade Cases Para 62,226 (N.D. Ohio) (August, 1976 complaint accuses Youngstown, Ohio hospitals and physicians of boycotting an HMO out of business); *Ohio v. Greater Cleveland Hospital Assn.*, No. C-80-1305 (N.D. Ohio) (July, 1980 complaint accuses a local hospital association of conspiring with its members to grant preferential prices to Blue Cross, collectively refusing and reducing competitive discounts, and agreeing not to compete in the insurance market); *Ohio v. Joint Commission for the Accreditation of Hospitals*, No. C-2-79-1158 (S.D. Ohio) (December, 1979 complaint charges JCAH with conspiring with the AMA and other physician organizations to eliminate competition from psychologists in hospitals); *Ohio v. Ohio Dental Assn.*, No. C-2-79-1058 (S.D. Ohio) (November, 1979 settlement ordered the divestiture of dentist control of Delta Dental Plan of Ohio and the elimination of ethics against contract practice); *Ohio v. Ohio Optometric Assn.*, No. C-2-80-388 (S.D. Ohio) (May, 1980 complaint against Ohio Optometric Association and Ohio Vision Services seeks divestiture of optometrist control of Ohio's largest vision benefit insurer and an end to anticompetitive restrictions on optometrist members); and *Ohio ex rel Brown v. Alliance Dental Society*, 1976-1 CCH Trade Cases, Para 60,944 (Ohio C.P.) (consent judgment against dentist boycott of state Medicaid Program).

SUMMARY OF ARGUMENT

A close examination of the Respondent medical society and foundations' fee agreements among 70% of area physicians reveals classic medical guild conduct wholly lacking in any redeeming values. Masked behind the high sounding labels "foundation," "cost containment," and "competitive alternative", is a simple collective bargaining agent with overwhelming market power negotiating physician fees with insurers. There is no partial integration by the physician members of the foundations incidental to the joint price-fixing, nor are there special features of the medical services market requiring such an enormous aggreagation of market power by the Respondents.

There are, moreover, far more competitive methods of providing "paid-in-full" insurance benefits than the foundation fee agreements, such as participating contracts. The Respondents' fee agreements eliminate these competitive alternatives, and thus foreclose competition in both the physician and insurance markets.

In the final analysis, the foundation fee agreements' purpose and effect is to perpetuate a guild model of health care delivery devoid of price competition among physicians. The unfortunate side effect for physicians and the public is the perpetuation of a system basically lacking self-correcting private incentives for efficiency and effectiveness. Accordingly, the Respondents price-fixing activities violate Section One of the Sherman Act under either a *per se* or truncated rule of reason analysis.

ARGUMENT

I. RELEVANT BACKGROUND ON THE HEALTH CARE INDUSTRY, THE GUILD MODEL AND THE COMPETITIVE ALTERNATIVES.

A. The Persistent Probelm of Soaring Health Care Costs.

That health care costs continue to soar, straining both public and private finances, is undisputed. Between 1970 and 1980, the nation's health care bill more than tripled to nearly

$250 billion, and in the next ten years is expected to triple again. Freeland, Calat & Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990,* 2:3 HEALTH CARE FINANCING REV. 1, 2 (1980). In Ohio, state and local government expenditures for health rose 315% in ten years to $1.3 billion in 1979, while overall governmental expenditures increased only 173% during the same period. *Ohio Governments' Spending climbs 173% in Past Decade,* Cleveland Plain Dealer, Nov. 20, 1980 at 10-B. The City of Cleveland was just informed of a 45% increase in the cost of Blue Cross hospital insurance for its employees. Clark, *Hospitalization Rates to Leap for City Workers,* Cleveland Plain Dealer, May 8, 1981 at 13-A.

Private sector health care costs have also been skyrocketing. Between 1965 and 1980, private spending climbed from $32 billion to $144 billion. Freeland, et al., *supra,* at 2.

Health care costs have been rising at least 50% faster than inflation generally for many years. *Id.,* at 2-4. Recent indications are that health care costs are about to rise even more sharply. According to a Blue Cross-Blue Shield actuary, "[t]he easy part is over. The tough sledding is ahead." Waldholz, *Medical-Benefit Costs are Rising Sharply; Firms Tighten Controls, Redesign Plans,* Wall Street Journal, Sept. 25, 1980 at 48.

B. The Underlying Cause: The Perverse Incentives, or the Absence of Price Competition Among Providers.

The underlying cause of the excessive escalation of costs is well known - perverse incentives. The existing incentives facing patients, doctors, and hospitals are cost-generating, not cost-saving. It is generally recognized that "[p]robably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge."[2]

---

2. HEW, *Forward Plan for Health: Fiscal Years 1980-1982* at 34 (1976). *See also* McClure, *The Medical Care System Under National Health Insurance; Four Models,* 1 J. HEALTH, POLITICS, POLICY & LAW 22, 33 (1976); Sen. Rep. on PL 93-141, No. 93-1285, 93d Cong., 2d Sess., *1974 U.S. Code & Admin. News* 7842, 7878.

Under the predominant forms of public and private health insurance, there is virtually no price competition between providers of health care services that give private incentives to doctors and hospitals to be efficient. In the system of "usual and customary fees" for physicians and cost reimbursement for hospitals that dominates health-care financing today, the question of the efficient use of resources does not even arise. Providers are not required to set priorities, look at alternatives and make hard choices. From the point of view of the provider, there is an apparently unlimited amount of money. This system rewards cost-increasing behavior with more revenue and punishes cost-reducing behavior with less revenue. Such a system must produce inflation in prices and waste in the use of resources.

To illustrate, it makes no difference to most patients whether they use the most extravagant doctor and hospital or the most efficient. For the vast majority of patients, insurance pays irrespective of choice. Reaping no reward, the rational consumer will forego the difficult effort of seeking out equally effective but less costly alternatives.

Under existing methods of reimbursement, the efficient physician is actually punished. The physician who avoids services of low or questionable efficacy, who substitutes less elaborate procedures for more costly procedures when equally effective, who treats in his office instead of the hospital whenever appropriate, loses income.

The general practitioner may refer a patient to a neurologist or a surgeon, order laboratory tests and x-rays and have the patient hospitalized. Physicians order services that directly or indirectly account for approximately 70% of all health care costs. Egdahl, *Fee For Service Health Maintenance Organizations,* 241 J.A.M.A. 588 (Feb. 9, 1979). Even though a physician's orders generate these costs, he or she has no "financial responsibility" for them. Thus, the physician has no incentive to seek out equally effective but less costly alternatives. "[M]ost physicians don't have the vaguest notion of what things they order cost." Am. Medical News, June 22, 1979 at 9 (quoting Dr. Darrell Cannon).

The same disincentives for efficiency and incentives for waste operate on hospitals. The hospital that closes excess capacity, avoids duplicative technology already located in nearby hospitals, screens out unnecessary admissions, and discharges patients as soon as medically appropriate, loses revenue.

Perverse incentives mean that doctors and other providers who do not restrain themselves are rewarded at the expense of those who do. Since extravagant medical care and conservative medical care are often equally medically effective but extravagant medical care is rewarded, a "spare no expense" mentality develops regardless of benefit that drives health care costs exorbitantly high – without any improvement in health outcomes.[3] Unless this system of perverse incentives that punishes cost-conscious behavior while rewarding inefficiency is changed, the health care industry will continue to experience unacceptably high inflation.

There are basically two approaches to solving the problem of perverse incentives - government regulation or private market incentives. Of course, the two approaches can be used in combination. *See generally* P. AREEDA & D. TURNER, 1 ANTITRUST LAW 133-78 (1978) (competition in regulated industries). The first, government regulation, attempts to use public economic controls as the substitute for missing market forces. One example of that approach is health planning, which is presently before the Court in *National Gerimedical Hospital v. Blue Cross of Kansas City*, No. 80-802 (argued 4-29-81).

3. V. FUCHS, WHO SHALL LIVE? (1974) & Enthoven, *Cutting Cost Without Cutting The Quality of Care*, 298 NEW ENGLAND J. MEDICINE 1229, 1234-35 (June 1, 1978) (curtailing "flat of the curve" medicine).

C. The Competitive Alternative: Provider Price Competition Over Fees and Premiums.

The second private market approach seeks to establish effective market forces for doctors and other providers in the health services market. Recently there has been a tremendous increase in both the interest in and number of proposals for using "competition" as a therapy for the health care field's feverishly high rates of inflation.[4]

The distinctive feature of the market apprach is not that it calls for competition between doctors and other health care providers, for there is already vigorous *non-price* competition at that level. *See, e.g.*, Williams, *How to Meet the New Demands in Ambulatory Care*, TRUSTEE, Dec., 1980 at 47. The distinctive feature is that it requires what the market requires: *price* competition at the provider level. In the words of Dr. Paul Ellwood, the person singularly most responsible for the development of the market approach, provider price competition is essential:

> There is one awesome condition that hospitals and physicians must meet if the market is to work fully: aggregations of doctors and hospitals have to compete with each other for comsumers on the basis of price. Price competition is a concept that is absent in health care throughout the world, but it is a necessity if price and expenditure controls are to be avoided.

---

4. *See, e.g., Competition in Health Care: Would it Bring Costs Down?* CONG. Q. 1587 (August 4, 1979) for a discussion of the legislative proposals. The competitive policy analyses that follow are summarized in Enthoven, *Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here*, NAT'L. J. 885 (May 26, 1979): McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH, POLITICS, POLICY & LAW 22 (1976); A. ENTHOVEN, HEALTH PLAN (1980); Enthoven, *Cutting Cost Without Cutting The Quality of Care*, 298 NEW ENGLAND J. MEDICINE 1229 (June 1, 1978); W. McClure, *Comprehensive Market and Regulatory Strategies for Medical Care* (Inter Study 1980). *See also* Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMPORARY PROBLEMS 716 (1970). For the effects of provider competition in health care, *see* Christianson & McClure, *Competition in the Delivery of Medical Care*, 301 NEW ENGLAND J. MEDICINE 812 (Oct. 11, 1979); *In re American Medical Association*, 94 F.T.C. 701, 1013, 1016-18, (1978).

Ellwood, *The Importance of the Market,* 2 J. HEALTH, POLITICS, POLICY & LAW 447, 448 (1978).

As this Court stated long ago, price is the "central nervous system of the economy." *United States v. Socony-Vacuum Oil Co.,* 310 U.S. 150, 226 n. 59 (1940). Thus, price competition among health care providers is central to a market solution for the health care cost problem. Price competition among health care providers is a concept that never received serious study and analysis until recently, except by medical societies. Recent policy analyses have identified two profoundly different ways in which providers can engage in price competition: first, over fees, and second, over premiums.

Price competition over fees seeks to introduce provider price competition when the consumer needs health care services by changing existing health insurance coverage to require the patient to pay a portion of his or her medical bill. If the consumer has to pay a portion of the bill, an incentive to select a doctor or hospital on the basis of price along with other factors emerges. An example of this approach are the proposals for catastrophic health insurance. *See, e.g.,* Feldstein, *A New Approach to National Health Insurance,* 23 PUBLIC INTEREST 93 (1971); McClure, *The Medical Care System Under National Health Insurance: Four Models,* 1 J. HEALTH, POLITICS, POLICY & LAW 22, 44-47 (1980).

The second method of introducing provider price competition and incentives for efficiency is to generate *provider competition over premiums.* It starts from the premise that consumers may prefer comprehensive health insurance coverage. If all provider fees are covered, then there obviously can be no provider competition for patients over fees. The only price mechanism available under comprehensive coverage is the premium itself.

However, present competition over premiums is between insurers, not health care providers. Provider price competition over premiums requires distinct groups of providers who offer their services for a premium. Thus, in order

> to establish market forces and incentives under insurance, providers must be split into competing groups.

Ellwood & McClure, *Health Delivery Reform* at 2 (unpublished Inter-Study paper, Nov. 17, 1976).

Each group of doctors and hospitals offering their services for a premium are called "health plans" in the literature on competitive policy for medical services. Health plans would compete with traditional forms of insurance, and would create choice and price competition among groupings of providers over premiums. Obviously, an efficient group of providers could have a lower premium than an inefficient group. In such systems, physicians would accept responsibility for providing comprehensive health-care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of health-care resources. Physicians control the lión's share of health-care expenditures, and are by far the best qualified to make the difficult judgments about need and cost effectiveness. It makes sense for physicians to accept the main responsibility for keeping health-care costs within the limits desired by society.

The classic example of a health plan is the closed panel health maintenance organization. It is only one of many forms that "health plans" can take, however. Other examples include Health Care Alliances and Individual Practice Associations, so long as the number of physicians involved do not have undue market power. Solo fee-for-service physicians who practice high quality medicine in a conservative and efficient manner which, under the present system is irrelevant to consumers, could ban together and organize a health plan. If they are efficient, then the premium for their health plan will be lower and people who chose it will receive more benefits for lower costs. On the other hand, it they pick providers who provide cheap and shoddy care, consumers would soon find out and switch to another plan. Or, if they choose providers who are good but expensive, the plan's premium would rise and consumers would look at their alternatives and pick a more cost-effective plan.

Thus, the market approach seeks to cure the single greatest cause of runaway health care inflation, perverse incentives, by altering the incentives facing doctors, hospitals and consumers. By altering incentives so that efficiency is encouraged, the private system will squeeze out its own excesses in a decentralized and diversified private market for health care services.

D. Medical Guild Opposition to Price Competition Among Providers.

Altering these perverse incentives requires introducing price competition among health care providers either over premiums or over fees. Provider price competition, however, is directly contrary to the medical guild mentality, and has been traditionally opposed by the profession. For more than 50 years, physician price competition has been considered unethical by the American Medical Association and its affiliated societies.

In a landmark ruling in 1978, the Federal Trade Commission documented at great length the use of medical society ethics to suppress price competition over fees and premiums. *In re American Medical Association.*[5] In addition to restraints on price advertising, the Commission struck down ethical restrictions that blocked physician price competition over premiums. Under the AMA's long established ethics, physicians were barred from entering into agreements with health plans or insurers that paid less than "usual fees", involved "underbidding", or were not open to any interested physician ("free choice"). 94 F.T.C. at 1012. According to the AMA, insurance arrangements that split physicians into groups competing over price were patently unethical:

5. 94 F.T.C. 701 (1978), *aff'd.* 1980-2 CCH Trade Cases Para 63,569 (D.C. Cir. 1980), *petition for cert. filed,* no. 81-1960 (1981). The administrative law judge's Nov. 13, 1978 opinion is 94 F.T.C. at 705, and the Commission's Oct. 12, 1979 affirming opinion 94 F.T.C. at 980.

> [I]t is evident from a facial examination of AMA's ethical provisions and from evidence concerning adoption of these restraints that they are *designed to limit price competition among doctors.*[6]

By rejecting price competition among physicians, the medical profession for over 50 years has fundamentally misperceived the nature of the free market system. Medical guild economics reverse private market principles. Contractual arrangements with health plans and insurers that create price competition among physicians are opposed as "unfair competi-

---

6. *In re American Medical Association,* 94 F.T.C. at 1014. (Emphasis added.) Over the 50 year period the medical profession's ethics against physician price competition have been in effect and vigorously enforced, they have also been imposed on existing health insurance. *See, e.g.,* Note, *American Medical Association: Power, Purpose & Politics,* 63 YALE L.J. 937, 976-96 (1954); A. SOMERS & H. SOMERS, DOCTORS, PATIENTS, & HEALTH INSURANCE, 261-340 (1960); *American Medical Assn. v. United States,* 317 U.S. 519 (1943); *In re American Medical Association, supra,* 94 F.T.C. at 1013.

It would be a grevious error in public policy to consider the medical profession's adamant resistance to insurance arrangements that promote price competition among physicians a thing of the past. The AMA is seeking to have this Court overturn the FTC's landmark ruling, *In re American Medical Association, supra, petition for cert. filed,* no. 81-1960 (1981). The AMA's Executive Vice President recently stated that the AMA would be "violently opposed" to changes in public health insurance programs contrary to a key ethical provision struck down by the FTC as a restraint of trade. *See* Schorr, *Reagan's Medicaid Plan Stirs Fears of Two-Class Health Care System,* Wall Street Journal, Feb. 24, 1981, at 25, & *In re American Medical Association, supra,* 94 F.T.C. at 1015. Also, an AMA delegate recently described the Enthoven competitive health plan proposals to be "socialized medicine" because, in essence, they were inconsistent with these same illegal ethics against physician price competition over premiums. Rogers, *Pro-competition Bills and Socialized Medicine,* American Medical News, May 8, 1981 at 8. Deep-seated medical guild policies are not easily eradicated.

tion" and "unethical". Contractual arrangements that eliminate physician price competition are viewed as "fair competition" and "ethical".[7]

The AMA and its affiliated medical societies have a deeply rooted commitment to this guild model:

7. *In re American Medical Association, supra.* This fundamental misunderstanding of private market economics is reflected in a string of cases brought by doctors and other health professionals against participating contracts used by health plans and insurance companies. *E.g., Anderson v. Medical Service of the District of Columbia,* 551 F.2d 304 (4th Cir. 1977); *Kartell v. Blue Shield of Massachusetts, Inc.,* 592 F.2d 1191 (1st Cir. 1979); *Grigg v. Blue Cross & Blue Shield of Michigan, Inc.,* No. 772990 (E.D. Mich., filed Dec. 22, 1977) (physicians); & Enright, *Doctors v. Blue Shield: The First Big Battle,* MEDICAL ECONOMICS 23 (Nov. 27, 1978). *See also Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 1981-1 CCH Trade Cases Para 63,885 (N.D. Calif. 1981) (pharmacists); *Manasen v. California Dental Service,* 1981-1 CCH Trade Cases Para 63,959 (N.D. Calif. 1980) (dentist); *Doctors, Inc. v. Blue Cross of Greater Philadelphia,* 557 F.2d 1001 (3rd Cir. 1976) (hospitals).

The provider plaintiffs in these cases are alleging, in essence, that it is "anti-competitive" for an insurance company-buyer to make provider-sellers compete over price for the insurer's business and to refuse to deal with providers whose fees are too high. In the guild model, price competition is a restraint of trade.

> Because medicine tenaciously retained the personal relations which are essential to the treatment of disease, it clung to many features of the *guild form of organization* and the ethics based on these relations.[8]

Whenever consumer demand for a new service threatens to trigger price competition among physicians, the new service is simply recast into the medical guild mold.

Hence, the guild model of the medical marketplace is the key to a proper evaluation of the price setting practices of the Respondents medical society and foundations in this case. The medical profession's response to potential physician competition over fees or premiums in Arizona has been the guild organization in the form of medical foundations.

---

8. AMA, ECONOMICS AND THE ETHICS OF MEDICINE 8 (1936) (Emphasis added). *See also* AMA, AN INTRODUCTION TO MEDICAL ECONOMICS 19 (1933) (Emphasis added):

> Recent national legislation proposes to extend the functions of such trade associations much further and to give them a very extensive control over the various industries and to hold them responsible for *the amount of production, for prices and for the competitive relations of their members. These are functions closely analogous to those long conducted by professional associations* and would seem to indicate that industry is finding it desirable to follow professional models rather than the reverse.

On the aggressive actions taken by medical societies to preserve the guild model, including boycott and collective bargaining, *see generally, In re American Medical Association, supra,* & Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?,* 58 MILBANK MEMORIAL FUND Q. 89 (1980).

II. THE MEDICAL SOCIETY FOUNDATIONS ARE ILLEGAL DOCTOR UNIONS COLLECTIVELY BARGAINING FEE AGREEMENTS FOR 70% OF AREA PHYSICIANS WITHOUT AN ANTITRUST EXEMPTION.

Careful examination of the undisputed facts in this case demonstrates that the Respondent medical society and foundations are mere fronts for classic guild conduct as to the challenged fee schedule agreements. The "foundations" are gauzy cloaks for the Respondents acting as "labor unions" collectively negotiating physician fees on behalf of 70% of area physicians with insurers - without benefit of labor's antitrust exemption. *American Medical Assn. v. United States,* 317 U.S. 519, 533-36 (1943) (medical society guild conduct on behalf of independent practitioners is not protected by the antitrust exemption for labor unions). *See generally* L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST 723-31, 719-22 (1977) (labor exemption and agricultural cooperatives exemption).

Under this Court's standards, the *per se* principle applies to "certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *Northern Pacific R. Co. v. United States,* 356 U.S. 1, 5 (1958). Agreements completely eliminating price competition among 70% of the providers of physician services without any redeeming virtues summarily violate Section One of the Sherman Act (15 U.S.C. Section 1) under either a *per se* or truncated rule of reason analysis. *See also National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978).

Respondents have asserted that a rule of reason analysis is appropriate because of the courts' unfamiliarity with the "medical foundation concept." A penetrating analysis of the undisputed facts in this case, however, demonstrates that the courts are, in fact, on familiar ground - the medical guild model. The foundation fee agreements' purpose and effect is to perpetuate a guild model of health delivery devoid of price competition among physicians.

It is undisputed that the Respondent medical society and foundations develop by agreement schedules of fees that are high enough to be acceptable to more than 70% of practicing physicians. Like a typical trade association or guild, the medical society foundation polls its physician members, consults with other medical associations and ultimately adopts an annual fee schedule only with the formal agreement of its physician members. (Pet. Brief for Cert. at 4).

It is further undisputed that the physician members have not integrated their practices in any way that requires joint price-fixing. The foundations are not insurers themselves. It is true that, in addition to setting agreed-to fees, the medical society foundations perform two other functions. First, foundations review the medical necessity and appropriateness of medical treatment and hospital utilization given to insured patients. Second, for some insured groups, the foundations also serve as agents for underwriters to facilitate claims payments to doctors. However, there is no suggestion, even by Respondents, that performance of either of these functions requires agreements on price. Clearly no such claim could be made, since the Maricopa Foundation provides these services to the State of Arizona's Comprehensive Medical Dental Program for Foster Children, and the state, not the Foundation, sets the physician fee levels. (Brief in Opp. to Cert. at 7).

In reality, then, the Respondent medical society foundations are simply illegal guilds or unions, which serve as the negotiating agent for "contracting physicians", and provide a "common front" in meeting "socioeconomic pressures." The Federal Trade Commission, in *In re American Medical Assn., supra,* made those precise findings as to similar medical society foundations in Connecticut:

> The [Connecticut State Medical Society] Council has urged the CSMS component medical societies to consider forming foundations for medical care on a county-by-county basis, each foundation to serve as the negotiating agent for contracting physicians in all matters having to do with third-party payments to physicians.

* * *

> Foundations "owned, controlled and administered by organized medicine" and incorporating fee-for-service medicine as a basic principle are one means available to medical societies to protect the interests of practicing physicians. They provide physicians with a "common front in meeting the socioeconomic pressures facing the practice of medicine," such as presented by HMOs, where fees are not necessarily controlled by doctors.

94 F.T.C. at 787-88. (Citations omitted).

The pernicious anticompetitive effects of the physician-controlled foundations here are manifest. As the collective bargaining agents for 1,000 physicians in Maricopa County and 400 physicians in Pima County, (Pet. Brief for Cert. at 3), the Respondent medical society foundations orchestrate a horizontal agreement on fees acceptable to fully 70% of all participating physicians. The foundations' fee agreements thus eliminate any actual or potential price competition among 70% of each area's physicians for the foundations' insurance company customers. This enormous market power is reminiscent of much earlier *per se* price-fixing cases. *See, e.g., Sugar Institute, Inc. v. United States,* 297 U.S. 553 (1936) (70-80%); *United States v. Frankfort Distilleries, Inc.,* 324 U.S. 293 (1945) (75%); *United States v. Line Material Co.,* 333 U.S. 287 (1948) (41%); and *United States v. Women's Sportswear Mfrs' Assn.,* 336 U.S. 460 (1949) (50%).

The Respondents and the Court of Appeals make much of the fact that the foundation fee agreements among physicians set "maximum" fees. Any agreement between a buyer and seller for the purchase of goods or services sets a "maximum" price. Certainly, every collective bargaining agreement sets a maximum price. The key issue is not whether a maximum or minimum price is set, but whether physician price competition is significantly restrained. A collective bargaining agreement on behalf of 70% of area physicians clearly restrains physician price competition to a significant extent.

Indeed, these medical society foundation fee agreements have more pernicious anticompetitive effects than the usual price-fixing agreement. Ordinary price-fixing agreements operate in industries where price-fixers have an incentive to break from the fold and obtain more business by undercutting the cartel price agreement. *See* R. POSNER, ANTITRUST 96-98 (1981). Here, there is no incentive for member physicians to break from the guild and charge lower fees because, under the foundations' fee agreements, the physician will not get any new business. And since patients with foundation-affiliated insurance have paid-in-full benefits, there is no incentive for the patient to seek out a physician that charges less than the foundation's fee schedule. Accordingly, there is no incentive for the physician to charge less than the foundation's fee schedule.

The fact that some doctors charge less than the medical society foundation fee schedules simply reflects the nature of the profession, not the glimmer of any physician price competition. This Court has long recognized that price-fixers can eliminate price competition without charging identical prices or rigidly following a fee schedule. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 225 n. 59 (1940). *Accord Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *Nationwide Trailer Rental System, Inc. v. United States*, 156 F. Supp. 800 (D. Kan.), *aff'd.* 335 U.S. 10 (1957). In *Plymouth Dealers Assn. v. United States*, 279 F.2d 128 (9th Cir. 1960), the Ninth Circuit concluded that it was illegal for competing new car dealers to agree upon a "list price", even though customers invariably bargained over the price and autos were rarely sold at that price. Here, Respondents have much greater market power than the Plymouth dealers. Even more significant is the fact that there is no incentive for patients to bargain over physicians' prices. Hence, the medical society foundations' fee agreements have far more anticompetitive effects than the price-fixing agreements held unlawful in *Plymouth Dealers, supra.*

No elaborate industry analysis is required to conclude that a schedule of fees collectively agreed to by over 70% of an area's practicing physicians is above competitive levels. Whether the medical society foundation fee schedules are higher or lower than what the same physicians charge in other non-competitive settings is not the critical comparison. The critical comparison is to fee levels that would be established by a more competitive

process than a guild. Collective fee agreements by over 70% of the providers of medical services are self-evidently higher than competitive levels and are inherently inflationary over time.

Perhaps the most pernicious effect of the foundations' horizontal fee agreements is that they perpetuate an insurance system devoid of price competition between physicians and inhibit private incentives for efficiency. By collecting together all the physicians interested in responding to a market for service benefits, the foundations stop cold a competitive chain reaction among physicians and insurers. Central to the medical guild mentality is the principle "united we stand, divided we fall". This principle makes any system of private market reform of the health care industry impossible. The private market will only work if some physicians are divided into groups competing on the basis of quality and efficiency. Ellwood, *supra.* The foundation fee agreements foreclose competition among insurers over alternative, more aggressive methods of minimizing the costs of medical services. *See Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979). Aggressive cost containment by insurers could in turn provoke groups of physicians without undue market power to form their own health plans to compete with insurers and their fellow physicians.

The affidavit of the executive director of the Maricopa Foundation for Medical Care, Anthony Mitten, confirms these anticompetitive effects. Mr. Mitten states that his Foundation "was established to provide. . .a competitive alternative to utilization of closed panel prepaid health insurance plans." First, his statement shows the vitality of competition in the physicians market, since competitive alternatives prompted the formation of the Foundation. *See In re American Medical Assn., supra,* 94 F.T.C. at 1013. Second, the medical society's "competitive" response was anticompetitive – countering "closed panel" health insurance plans. "Closed panel" is the medical profession's code word for plans that generate price competition among physicians. *See, e.g.,* F.T.C. Bureau of Competition, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans* 280-301 (April, 1979) (hereafter "FTC Report"); *In re American Medical Assn., supra.* Thus the medical society foundation fee agreements foreclose competition in both the physician services and insurance markets over innovative methods of financing health care.

Furthermore, there are no redeeming values to the foundations' fee agreements that cannot be achieved in far less anticompetitive ways, nor special characteristics of the physician services market that save them from *per se* or truncated rule of reason illegality.

It is undisputed that the foundations' fee agreements are separate and distinct from the other foundation services. The foundations' fee agreements, like the pharmacy agreements in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979), "are merely arrangements for the purchase of goods and services by" insurers. There are far more competitive ways for insurers to purchase physician services than through collective negotiations with medical society guilds representing 70% of the physician market. As the Court found in *Royal Drug, supra,* an insurer could use participating contracts, exclusive contracts, and even integrate into the physician services market.[9] There is nothing unique in the market for medical services, other than the unlawful ethical restrictions on physician price competition (documented in the 1978 FTC *American Medical Association* ruling), that makes it impracticable for insurers to establish maximum payment agreements with physicians.

Participating contracts with physicians or other health care providers have been used by some insurers for years. *See, e.g.,* F.T.C. Report, at B3-B9; *Royal Drug Co., supra.* Each insurer develops its own participating contract according to its own blend of goals, needs, bargaining position, market demand and abilities, and offers it unilaterally by mail to each physician. Collective negotiations with physicians are no more necessary than collective negotiations with policyholders over standard form contracts.

---

9. *Id.* at 215. *See also* P. WILLIAMS, THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT (1932); AMA, NEW FORMS OF MEDICAL PRACTICE (1933). These publications demonstrate that service benefits were the predominant form of what is now called health insurance before commercial insurers or Blue Cross-Blue Shield plans were in the market. The health profession's Blue Cross-Blue Shield plans were first established in the early 1930's, after these publications on service benefit plans were printed. *See* O. ANDERSON, BLUE CROSS SINCE 1929 at 31-35 (1975).

Consistent with the competitive diversity of private markets, the fee levels and conditions of participation may vary considerably between insurers. Some may choose to use incentives for physicians to sign their participating agreements, such as paying nothing for services rendered to non-participating physicians, or circulating lists of participating providers to patients. *E.g., Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F.2d 1191 (1st Cir. 1979). Another incentive that is often used is to pay participating providers directly, rather than the patient, thus improving a doctor's cash flow and reducing bad debts. Non-participating doctors, on the other hand, must collect their fees from their patients, who are then indemnified by their insurers. *See, e.g., Anderson v. Medical Service of the District of Columbia,* 1976-1 CCH Trade Cases Para 60,884 (E.D. Va. 1976). Participating physician contracts have been used by different insurers for years, covering from 130 to nearly 20,000 physicians, and from 24% to 99% of practicing physicans. FTC Report at B3-B9. Participating contracts have long been used by commercial insurers as well as Blue Shield plans. *See, Hearings on Third Party Prepaid Prescription Programs before the Subcommittee on Environmental Problems Affecting Small Business of the H. Select Comm. on Small Business,* 92d Cong., 1st Sess., 227-70 (1971).

There is even a less restrictive alternative available to medical societies or their foundations. It would be perfectly lawful for a medical society or foundation to gather statistics on physician fees. G. LAMB & C. SHIELDS, TRADE ASSOCIATION LAW & PRACTICE 34-53 (1971). The medical society or foundation could provide that information for a fee to insurers to use unilaterally in setting physician reimbursement in their participating contracts.

In addition to participating contracts, insurers may enter into exclusive dealing agreements with a group of physicians or integrate into the physician services market and have physicians on salary. INA Health plan of Arizona in Phoenix, a group practice health maintenance organization recently acquired by INA, is illustrative. *See* Dept. Health & Human Services, 3 HMO Focus 1 (Dec., 1980) & 4 HMO Focus 1 (Feb., 1981) (INA also active in HMOs). *See generally* Tax Expenditures for Health Care, *Hearings before the Task Force on Tax Expendi-*

tures & Tax Policy of the H. Comm. on the Budget, 96th Cong., 1st Sess. at 235, 241-46 (1979). (Ellwood statement); A. Enthoven, *Consumer-centered v. Job-centered Health Insurance*, 57 HARVARD BUS. REV. 141 (Jan. 1979).

Commercial insurers have generally used participating contracts with non-physicians such as pharmacists. However, the primary reason *commercial* insurers have not used participating contracts and other competitive arrangements extensively with *physicians* is that such arrangements "violated" medical society "ethics", despite the lack of any practical or administrative barrier to their use. As noted earlier, the AMA's ethics held to be unlawful restraints of trade just recently in *In re American Medical Association, supra,* made it unethical for physicians to enter into contracts "which affect the adequacy of fees, involve underbidding, or preclude free choice of physician." 94 F.T.C. at 1012. The two medical societies involved in this case as AMA affiliates were bound to follow and enforce these anticompetitive ethics for over 50 years. 94 F.T.C. at 997. The Respondent Maricopa County Medical Society was specifically found by the trial judge in *In re American Medical Assn., supra,* 94 F.T.C. at 830-33, to have used these ethics to combat competitive alternatives. Since strong insurer participating contracts could be expected to be vigorously opposed by local medical societies as "unethical", the foundations' agreements were in many respects insures only alternative. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303. Thus, it would be building antitrust violation upon antitrust violation to legitimatize the foundation or guild fee agreements.

Accordingly, even an American Medical Association attorney recognized as "one of the nation's foremost experts on health law" strongly recommends that medical societies stop any collective fee negotiations with insurers:

> Third-party plans need stabilized physicians' fees in order to determine premiums for medical and health insurance. Some medical societies have previously assisted in the process, but this is now quicksand. If you are running a committee to help third-party payers determine what is reasonable payment for physicians' services, stop.

> Third-party payers can themselves hire practicing physicians on a part-time basis, if they wish. But it should not be done by a medical society.

Breo, *Antitrust and the Medical Society*, 76 OHIO ST. MED. J. 136, 140 (March, 1980) (Emphasis added).

Therefore, close examination of the Respondents and their physician fee agreements reveals classic guild conduct wholly lacking in redeeming values and justification. Masked behind the high sounding labels "foundation", "cost containment", and "competitive alternative", are medical society guilds with overwhelming market power collectively bargaining over physician fee levels. Like a cancer, the medical guild model spreads to any part of the marketplace where price competition might break out among physicians. Its spread to the Respondents' foundation fee agreements should be halted now. Accordingly, the Court should hold these price-tampering agreements by medical professionals illegal under either a *per se* or truncated rule of reason analysis. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *National Society of Professional Engineers, supra.*

At the same time, the Court should make clear that the private market principles of the antitrust laws do not mean that every combination of physicians is illegal. Central to the illegality in this case is the overwhelming market power of 70% of the area physicians represented by Respondents. Smaller aggregations of health care providers offering new services and efficiencies are lawful so long as the loss of provider price competition between participants is not too great.

The guild mentality has created an erroneous "all or nothing" logic among physicians. Many doctors fear that the only alternative to "all" uniting in a guild is the other extreme, the individual physician facing large buyers alone. In fact, there is a vast middle ground of partial and full integrations among physicians that are judged by merger and joint venture standards and are perfectly lawful:

> [Arrangements] . . . where there is substantial but not complete integration of production, managerial, distribution, financial or other operations will be considered [joint ventures]. Without such integration, the "joint venture" label simply masks a consensual cartel, and there is no reason to displace established antitrust rules governing cartel conduct. And, of course, when there is complete or substantially complete integration between the parent companies, merger rules would apply.

Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin,* 82 HARVARD L. REV. 1007, 1016 (1969).

Physicians in private practice do not have to give up their independent practices. They can partially integrate their practices and not be guilty of *per se* price fixing:

> [T]wo conditions. . .must be met before a partial integration reducing price competition escapes *per se* treatment. The first is that the price restraint must arise inevitably from the integration.* * * *
>
> * * * *
>
> The second contition to be met before a partial integration which ends price competition escapes the *per se* ban is one which requires the court to look at structure at least in a truncated way. If the arrangement appears likely to dampen price competition market-wide by ending price competition between participants, it will be *per se* unlawful despite the integration.

L. SULLIVAN, *supra,* at 208-09.

There is a vast area where the private market for medical care can function properly with price competition among

health care providers. In it, physicians can group together in a variety of forms and arrangements as long as provider price competition and incentives for efficiency are preserved.

In the final analysis, market principles apply to medical care not because there are no differences between medical services and cars, steel, airplanes, tires and computers, but because all have one thing in common: the economic question of the best allocation of society's limited resources. Given the dilemma that society's resources are not infinite, there are only three basic ways of allocating scarce economic resources – competition, government regulation, and a combination of both. No choice is problem-free, and all have their drawbacks. To avoid extensive government regulation of medical practice, price competition among physicians and other providers is the only alternative. Price competition imposes the discipline on private markets without which free markets cannot operate.

The Respondents' foundation fee agreements perpetuate a guild model of medical health care delivery and inhibit price competition among physicians, and should, therefore, be struck down by this Court. Once freed from the shackles of guild thinking, a properly functioning private market for health care is possible and preferable for consumers and providers alike.

CONCLUSION

For the foregoing reasons, the decision of the Ninth Circuit should be reversed, and summary judgment granted in favor of Petitioner, State of Arizona.

Respectfully submitted,

WILLIAM J. BROWN
Attorney General of Ohio

CHARLES D. WELLER
Assistant Attorney General
Counsel of Record for State of Ohio

DOREEN C. JOHNSON
Assistant Attorney General

810 State Office Building
615 West Superior Avenue
Cleveland, Ohio 44113
(216) 622-3030

Counsel for State of Ohio
Amicus Curiae

of Counsel:

EUGENE F. McSHANE
Assistant Attorney General
Chief, Antitrust Section